STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	08/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DRIVE FORT WAYNE, IN46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00094006. Complaint IN00094006-Substantiated. Federal/ State deficiencies related to the allegations are cited at F282, F312, F353 and F441. Unrelated deficiencies are cited. Survey dates: August 3, 4, and 5, 2011. Facility number: 000476 Provider number: 155446 AIM number: 100290870 Survey team: Christine Fodrea, RN TC Julie Wagoner, RN Census bed type: SNF/NF: 132 Total: 132 Census payor type: Medicare: 13 Medicaid: 88 Other: 31 Total: 132 Sample: 11	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on August 10, 2011 by Bev Faulkner, RN			
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interview and record review, the facility failed to formulate approaches and interventions specific and individualized for each resident for 3 of 10 residents reviewed for individualized care plans in a sample of 11. (Resident #C, Resident #D, and Resident #H)	F0279	F 279 1. Resident's C, D, and H care plans were revised to include frequency of continence management and method of transfer. 2. All resident care plans will be reviewed to ensure continence management plans and methods of transfer are included and updated as appropriate. 3. Licensed staff will be	08/30/2011

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	Findings include: 1. On 08/04/11 at 9:20 A.M., Resident #C was observed seated in a Broda reclining chair in the hallway near her room. She was pushed into the doorway of her room at 10:20 A.M. She remained in her wheelchair in the doorway to her room, until 10:55 A.M., when she was taken by staff to the assisted dining room. The resident was not checked for incontinence or toileted. At 12:25 P.M., on 08/04/11, Resident #C was observed back in her Broda chair in the doorway to her room. She remained in her Broda chair until 1:22 P.M., when CNA's #3 and #6 placed her in bed and changed her brief. She was not toileted. Resident # C's record was reviewed 8/4/2011 at 1:45 p.m. Resident C's diagnoses included but were not limited to; heart failure, high blood pressure and osteoporosis. Resident #C's care plan, dated 3/2011, indicated she was to be toileted with a two person physical assist, but the care plan did not indicate the frequency. 2. Resident #D was observed on 08/03/11 at 7:00 P.M., seated in her room in her wheelchair beside her bed. Her roommate, alert and oriented Resident #S,		inserviced on including specific continence management plans and methods of transfer on care plans. IDT will monitor compliance during routine rounds. Results of audits will be forwarded to QA&A for tracking and trending monthly times 3 months then quarterly thereafter	

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	was noted to frequently come out into the hallway to the nurse's station and request assistance for her roommate, Resident #D. Resident #D remained in her wheelchair beside her bed until 7:53 P.M., when she was transferred by four staff into her bed, CNA #5 and 8, and LPN #10 and 12. Resident #D's record was reviewed 8/5/2011 at 8:10 a.m. Resident #D's diagnoses included but were not limited to diabetes, stroke, and seizure disorder. Resident #D's care plan, dated 8/2011, indicated she was to be toileted with a two person physical assist, but the care plan did not indicate the frequency or that a Hoyer lift (mechanical) was to be used. 8. On 08/03/11 at 7:00 P.M., Resident #H was observed in her wheelchair beside her bed. CNA #8 was noted to be in the room changing the bed linens. Resident #H was heard requesting to go to bed. She indicated she was hurting because she had been sitting so long (in her wheelchair). At 7:35 P.M., Resident #H was noted to be her bed. Interview with CNA #8 on 08/03/11 at 10:00 P.M., indicated she had toileted Resident #H before supper about 5:30 P.M., when she got her up from bed. She indicated the resident had not been			

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	checked again for incontinence until she was placed in bed. Resident #H's record was reviewed 8/4/2011 at 1:00 p.m. Resident #H's diagnoses included but were not limited to dementia, osteoarthritis, and Osteoporosis. Resident #H's care plan, dated 7/2011, indicated she was to be toileted with a two person physical assist, but the care plan did not indicate the frequency or that a Hoyer lift was to be used. In an interview on 8/5/2011 at 11:20 A.M., the Director of Nursing indicated the care plan forms the facility was using were not specific enough and the facility was working on changes. 3.1-35(a)			
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interviews, the facility failed to ensure health care plans regarding toileting and incontinence needs were followed for 8 of 11 dependent residents. (Resident #I, K, E, G, F, C, D, and H)	F0282	F 282 1. Resident's I, K, G, F, C, D, and H have been reviewed and have not experienced any negative outcome. 2. All residents have been reviewed to ensure specific toileting and incontinence needs are being	08/30/2011

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	Findings include: 1. Resident # I was observed on 08/03/11 at 7:00 P.M., lying in her bed asleep. The resident remained in her bed from 7:00 P.M. - 11:04 P.M., and was not checked for incontinence or offered toileting. On 08/04/11 at 9:20 A.M., Resident #I was noted to be in the main lounge at a Catholic church service. Resident #I remained in the main lounge until 11:21 A.M., when the Beautician, whose shop was located adjacent to the main lounge, indicated the resident was taken from the main lounge to the dining room by activity staff. At 1:12 P.M., CNA #6 was noted to assist Resident #I to bed. Interview with CNA #6, at this time, indicated the resident was a one person transfer and she was to be checked and changed. She indicated she changed the resident when she put her to bed, but she did not offer to toilet the resident. The clinical record for Resident #I was reviewed on 08/04/11 at 2:00 P.M. The most recent Minimum Data Set (MDS) assessment, completed on 07/17/11, indicated Resident #I was always incontinent of her bowels and bladder and required extensive staff assistance for		followed with no negative outcome noted. 3. Nursing staff will be inserviced on the importance of implementing and following continence management plans developed for each resident. Nursing supervisors will monitor compliance 5x weekly through unit rounds. Results of audits will be forwarded to QA&A for tracking and trending monthly times 3 months then quarterly thereafter	

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	toileting needs. Review of the current health care plan for Resident #I, current through 09/11, indicated the resident was a one person assist to transfer and was to be checked for incontinence every two hours. 2. Resident #K was observed on 08/03/11 at 7:00 P.M., seated in a reclining Broda chair by the nurse's station. The resident was noted to be actively trying to get up out of her chair. At 7:27 P.M., LPN's #10 and #12 pushed Resident #K to her room, changed her and put her to bed. From 7:27 - 11:04 P.M., Resident #K remained in her room in her bed. She was not checked for incontinence. Interview with CNA #5, on 08/03/11 at 10:00 P.M., indicated Resident #K had been in bed in the afternoon and had been checked for incontinence prior to getting her up for supper. On 08/04/11 at 9:20 A.M., Resident #K was observed seated in her reclining Broda chair by the nurse's station asleep. The resident remained in her reclining chair from 9:20 A.M. - 10:55 A.M., when she was pushed by CNA #3 to the assisted dining room for lunch.			

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	At 12:20 P.M., CNA #3 put Resident #K to bed and changed her incontinence brief. The clinical record for Resident #K was reviewed on 08/04/11 at 10:00 A.M. The most recent MDS assessment for Resident #K, completed on 07/05/11, indicated the resident required extensive staff assistance of two for toileting needs, and was always incontinent of her bladder and frequently incontinent of her bowels. The current health care plans for Resident K, current through 11/11, indicated the resident required two staff for transferring and toileting needs and was to be checked for incontinence every two hours. 3. On 08/04/11 at 9:20 A.M., Resident #G was observed seated in her wheelchair across from the nurse's station. The resident indicated she needed help because she was afraid of people trying to "get her." LPN #9 was alerted and reassured and talked with Resident # G. Resident #G remained in her wheelchair across from the nurse's station from 9:20 - 11:09 A.M. At 11:09 A.M., LPN #9 pushed Resident #G to the assisted dining room. She was not toileted or offered to be changed prior to going to the dining room. At 12:25 P.M., on 08/04/11, Resident #G			

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	was noted to be in her wheelchair in the main lounge, awake, watching television. At 1:25 P.M., LPN #9 pushed Resident #G from the main lounge to her room and left her in her wheelchair beside her bed. At 2:00 P.M., CNA's #3 and #6 transferred Resident #G to her bed and changed the resident. Resident #G's brief was wet, there were scars from previous open areas, but the resident skin was not open. Interview with LPN #10 during the initial tour of the facility, conducted on 08/03/11 at 8:10 P.M., indicated Resident #G was incontinent of her bowels and bladder, required the use of a mechanical lift for transfers, and had an open area of her bottom. The clinical record for Resident #G was reviewed on 08/05/11 at 9:30 A.M. The most recent MDS assessment for Resident #G, completed on 06/09/11, indicated the resident required extensive staff assistance of two for transferring and toileting needs and was frequently (more than seven incontinent episodes in seven days) incontinent of her bladder and occasionally incontinent of her bowels. The current health care plan for Resident #G, current through 09/11, indicated since 03/31/11 the residents toileting needs			

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were for "Incontinence Management" and the resident was to be checked every two hours, the care plan also indicated the resident was to be transferred with a mechanical lift.

4. Resident #F was observed on 08/03/11 at 7:00 P.M., lying in her bed. She remained in her bed, from 7:00 P.M. - 11:04 P.M., and no staff were noted to perform any incontinence care for Resident #F. Interview with CNA #8, on 08/03/11 at 7:00 P.M., indicated Resident #F had been in bed when she started her shift and she had been checked and changed before she was gotten up for supper.

On 08/04/11 at 9:20 A.M., Resident #F was observed lying in a reclining Broda chair across from the nurse's station. She remained in the Broda chair asleep from 9:20 A.M. - 10:45 A.M. At 10:45 A.M., two unidentified nursing staff members were observed to reposition and pull the resident up in the Broda chair. At 11:04 A.M., CNA #3 pushed Resident #F to the assisted dining room. She was not checked for incontinence or toileted.

On 08/04/11 at 12:25 P.M., Resident #F was observed still in her Broda chair by the nurse's station in the hallway. At 1:00 P.M., CNA's #3 and #6 transferred

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	Resident #F from her reclining chair to her bed with a mechanical lift. The resident's brief was changed and the resident was noted to have been incontinent of both her bladder and bowels. The clinical record for Resident #F was reviewed on 08/04/11 at 10:35 A.M. The most recent MDS assessment for Resident ##F, completed on 06/30/11, indicated the resident was always incontinent of her bowels and bladder and required extensive staff assistance of two for toileting needs. The current health care plan for Resident #F, current through 09/03/11, indicated the resident was to receive "Incontinence Management" and was to be checked every two hours (for incontinence). 5. On 08/04/11 at 9:20 A.M., Resident #E was noted to be in his wheelchair in the main lounge at an activity. He remained in the main lounge from 9:20 - 11:20 A.M. At 11:20 A.M., CNA #6 put his feet up on the wheelchair pedals and pushed him directly to the dining room. The resident was not toileted or checked for incontinence. On 08/04/11 from 12:25 P.M. - 12:40 P.M., Resident #E was noted to be			

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	visiting with family members. At 1:30 P.M., Resident #E was transferred by CNA's #3 and #6 from the wheelchair into his bed. The resident's brief was wet and there was a slight smear of bowel movement noted. The clinical record for Resident #E was reviewed on 08/04/11 at 1:05 P.M. The most recent MDS assessment for Resident #E, completed on 07/29/11, indicated the resident required extensive staff assistance of two for toileting needs, and was totally incontinent of his bladder and frequently incontinent of his bowels. The current health care plans, current as of 08/11, indicated the resident required an "Incontinence Management" program and was to be checked every two hours for incontinence. 6. On 08/04/11 at 9:20 A.M., Resident #C was observed seated in a Broda reclining chair in the hallway near her room. She was placed in the doorway of her room at 10:20 A.M. She remained in her wheelchair in the doorway to her room, until 10:55 A.M., when she was taken by staff to the assisted dining room. The resident was not checked for incontinence or toileted. At 12:25 P.M., on 08/04/11, Resident #C was observed back in her Broda chair in the doorway to her room. She remained in her Broda			

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	chair until 1:22 P.M., when CNA's #3 and #6 placed her in bed and changed her brief. She was not toileted. Resident # C's clinical record was reviewed 8/4/2011 at 1:45 p.m. Resident #C's diagnoses included but were not limited to; heart failure, high blood pressure and osteoporosis. Resident #C's care plan dated 3/2011 indicated she was to be toileted with a two person physical assist, but the care plan did not indicate the frequency. Resident #C's Minimum Data Set, dated 6/7/2011, indicated she was extensive assistance with toileting and needed two person physical assistance. 7. Resident #D was observed on 08/03/11 at 7:00 P.M., seated in her room in her wheelchair beside her bed. Her roommate, alert and oriented Resident #S, was noted to frequently come out into the hallway to the nurse's station and request assistance for her roommate, Resident #D. Resident #D remained in her wheelchair beside her bed until 7:53 P.M. when she was transferred by four staff into her bed, CNA's #5 and 8, and LPN's #10 and 12. Resident #D's buttocks was noted to be bright red and she had an open area on her			

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	right upper buttocks, and she had been incontinent of her bowels. Interview with CNA #8, on 08/03/11 at 10:00 P.M., indicated Resident #D had been transferred to her bed the previous evening by ambulance staff after having been readmitted from an acute care center to the facility. She indicated she was unable to toilet and/or check the resident prior to 7:53 P.M., when she was observed being transferred to her bed because she needed assistance and was unsure of the method going to be utilized to transfer Resident #D. Interview on 8/3/2011 at 7:35 P.M., with Resident #D and her roommate, Resident #S, indicated she had not been toileted since she had received a shower around 10:30 A.M. On 08/04/11 at 10:00 A.M., Resident #D was changed and transferred to her wheelchair by CNA's #3 and #6. She remained in her wheelchair in the hallway by the telephone until 11:12 A.M., when she was taken to the shower room by CNA #13 and weighed in her wheelchair. She was then placed back by the telephone and the nurse's station on the East unit. At approximately 11:20 A.M., Resident #D was pushed in her wheelchair by LPN #9 to the dining room			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for lunch. She was not toileted or checked for incontinence prior to being taken to the dining room. On 08/04/11 at 12:25 P.M., Resident #D was again in her wheelchair by the nurse's station. At 1:12 P.M., LPN #9 pushed Resident #D back to her room to braid her hair. She was immediately placed back out in the hallway by the nurse's station after her hair was braided. She was not toileted. At 2:00 P.M., Resident #D remained in her wheelchair in the hallway across from the nurse's station. Resident #D indicated her husband was picking her up to go to her grandson's birthday party around 2:00 P.M. Resident #D was not toileted prior to leaving for the party at 2:10 P.M. Resident #D's record was reviewed 8/5/2011 at 8:10 a.m. Resident #D's diagnoses included but were not limited to diabetes, stroke, and seizure disorder. Resident #D's care plan, dated 8/2011, indicated she was to be toileted with a two person physical assist, but the care plan did not indicate the frequency or that a Hoyer lift was to be used. Resident #D's Minimum Data Set, dated 7/20/2011, indicated she was extensive assistance with toileting and needed two			

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	155446	A. BUILDING 00 B. WING	08/05/2011

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	person physical assistance. 8. On 08/03/11 at 7:00 P.M., Resident #H was observed in her wheelchair beside her bed. CNA #8 was noted to be in the room changing the bed linens. Resident #H was heard requesting to go to bed. She indicated she was hurting because she had been sitting so long (in her wheelchair). At 7:35 P.M., Resident #H was noted to be her bed. Interview with CNA #8 on 08/03/11 at 10:00 P.M., indicated she had toileted Resident #H before supper about 5:30 P.M., when she got her up from bed. She indicated the resident had not been checked again for incontinence until she was placed in bed. Resident #H's record was reviewed 8/4/2011 at 1:00 p.m. Resident #H's diagnoses included but were not limited to dementia, osteoarthritis, and Osteoporosis. Resident #H's care plan, dated 7/2011, indicated she was to be toileted with a two person physical assist, but the care plan did not indicate the frequency or that a Hoyer lift was to be used. Resident #H's Minimum Data Set assessment, dated 7/15/2011, indicated			

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	she was extensive assistance with toileting and needed two person physical assistance. This Federal tag relates to Complaint IN00094006. 3.1-35(g)(2)			

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F0312 SS=E	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interviews, the facility failed to provide toileting and/or incontinence care for 8 dependent residents in a sample of 11. (Resident C, D, E, F, G, H, I, and K) Findings includes: 1. Resident #I was observed on 08/03/11 at 7:00 P.M., lying in her bed asleep. The resident remained in her bed from 7:00 P.M. - 11:04 P.M. and was not checked for incontinence or offered toileting. At 10:10 P.M., CNA's #5 and #8 had left and there was only one CNA left working on the floor. CNA #11 indicated she worked alone until 12:00 midnight when another CNA came in to work. On 08/04/11 at 9:20 A.M., Resident #I was noted to be in the main lounge at a Catholic church service. Resident #I remained in the main lounge until 11:21 A.M., when the Beautician, whose shop was located adjacent to the main lounge, indicated the resident was taken from the main lounge to the dining room by activity staff.	F0312	F 312 1. Resident's I, K, G, F, C, D, and H have been reviewed and have not experienced any negative outcome. 2. All residents have been reviewed to ensure specific toileting and incontinence needs are being followed with no negative outcome noted. 3. Nursing staff will be inserviced on the importance of implementing and following continence management plans developed for each resident. Nursing supervisors will monitor compliance 5x weekly through unit rounds. 4. Results of audits will be forwarded to QA&A for tracking and trending monthly times 3 months then quarterly thereafter.	08/30/2011

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	At 1:12 P.M., CNA #6 was noted to assist Resident #I to bed. Interview with CNA #6 indicated the resident was a one person transfer and she was to be checked and changed. She indicated she changed the resident when she put her to bed, but she did not offer to toilet the resident. The CNA indicated Resident #I had been incontinent of her bladder. The clinical record for Resident #I was reviewed on 08/04/11 at 2:00 P.M. The most recent Minimum Data Set (MDS) assessment, completed on 07/17/11, indicated Resident #I was always incontinent of her bowels and bladder and required extensive staff assistance for toileting needs. Review of the current health care plan for Resident #I, current through 09/11, indicated the resident was a one person assist to transfer and was to bed checked for incontinence every two hours. 2. Resident #K was observed on 08/03/11 at 7:00 P.M., seated in a reclining Broda chair by the nurse's station. The resident was noted to be actively trying to get up out of her chair. At 7:27 P.M., LPN's #10 and #12 pushed Resident #K to her room, changed her and put her to bed. From 7:27 - 11:04 P.M., Resident #K			

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	remained in her room in her bed. She was not checked for incontinence. Interview with CNA #5, on 08/03/11 at 10:00 P.M. indicated Resident #K had been in bed in the afternoon and had been checked for incontinence prior to getting her up for supper. On 08/04/11 at 9:20 A.M., Resident #K was observed seated in her reclining Broda chair by the nurse's station asleep. The resident remained in her reclining chair from 9:20 A.M. - 10:55 A.M., when she was taken by CNA #3 to the assisted dining room for lunch. At 12:20 P.M., CNA #3 put Resident #K to bed and changed her incontinence brief. Resident #K was observed on 8/5/11 at 11:10 A.M., receiving incontinence care. Her brief was saturated. Her skin was pink and intact. The clinical record for Resident #K was reviewed on 08/04/11 at 10:00 A.M. The most recent MDS assessment for Resident #K, completed on 07/05/11, indicated the resident required extensive staff assistance of two for toileting needs, and was always incontinent of her bladder and frequently incontinent of her bowels.			

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	The current health care plans for Resident K, current through 11/11, indicated the resident required two staff for transferring and toileting needs and was to be checked for incontinence every two hours. 3. On 08/04/11 at 9:20 A.M., Resident #G was observed seated in her wheelchair across from the nurse's station. The resident indicated she needed help because she was afraid of people trying to "get her." LPN #9 was alerted and reassured and talked with Resident #G. Resident #G remained in her wheelchair across from the nurse's station from 9:20 - 11:09 A.M. At 11:09 A.M., LPN #9 pushed Resident #G to the assisted dining room. She was not toileted or offered to be changed prior to going to the dining room. At 12:25 P.M.,on 08/04/11, Resident #G was noted to be in her wheelchair in the main lounge, awake, watching television. At 1:25 P.M., LPN #9 pushed Resident #G from the main lounge to her room and left her in her wheelchair beside her bed. At 2:00 P.M., CNA's #3 and #6 transferred Resident #G to her bed and changed the resident. Resident #G's brief was wet, there were scars from previous open areas, but the resident's skin was not open, red or appear macerated. CNA #6 indicated Resident #G had recently had an			

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	open area on her buttocks and did not like to lay down. Interview with LPN #10 during the initial tour of the facility, conducted on 08/03/11 at 8:10 P.M. indicated Resident #G was incontinent of her bowels and bladder, required the use of a mechanical lift for transfers, and had an open area of her bottom. The clinical record for Resident #G was reviewed on 08/05/11 at 9:30 A.M. The most recent MDS assessment for Resident #G, completed on 06/09/11, indicated the resident required extensive staff assistance of two for transferring and toileting needs and was frequently (seven occurrences of incontinence within seven days) incontinent of her bladder and occasionally incontinent of her bowels. The current health care plan for Resident #G, current through 09/11, indicated since 03/31/11, the resident's toileting needs were for "Incontinence Management" and the resident was to be checked every two hours. The care plan also indicated the resident was to be transferred with a mechanical lift. 4. Resident #F was observed on 08/03/11 at 7:00 P.M., lying in her bed. She remained in her bed, from 7:00 P.M. -			

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	11:04 P.M., and no staff were noted to perform any incontinence care for Resident #F. Interview with CNA #8, on 08/03/11 at 7:00 P.M., indicated Resident #F had been in bed when she started her shift and she had been checked and changed before she was gotten up for supper. On 08/04/11 at 9:20 A.M., Resident #F was observed lying in a reclining Broda chair across from the nurse's station. She remained in the Broda chair asleep from 9:20 A.M. - 10:45 A.M. At 10:45 A.M., two unidentified nursing staff members were observed to reposition and pull the resident up in the Broda chair. At 11:04 A.M., CNA #3 pushed Resident #F to the assisted dining room. She was not checked for incontinence or toileted. On 08/04/11 at 12:25 P.M., Resident #F was observed still in her Broda chair by the nurse's station in the hallway. At 1:00 P.M., CNA's #3 and #6 transferred Resident F from her reclining chair to her bed with a mechanical lift. The resident's brief was changed and the resident was noted to have been incontinent of both her bladder and bowels. There were deep indentations on the resident's skin where the brief had been. Resident #F's skin was deep pink in color with no open areas.			

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	The clinical record for Resident #F was reviewed on 08/04/11 at 10:35 A.M. The most recent MDS assessment for Resident ##F, completed on 06/30/11, indicated the resident was always incontinent of her bowels and bladder and required extensive staff assistance of two for toileting needs. The current health care plan for Resident #F, current through 09/03/11, indicated the resident was to receive "Incontinence Management" and was to be checked every two hours (for incontinence). 5. On 08/04/11 at 9:20 A.M., Resident #E was noted to be in his wheelchair in the main lounge at an activity. He remained in the main lounge from 9:20 - 11:20 A.M. At 11:20 A.M., CNA #6 put his feet up on the wheelchair pedals and pushed him directly to the dining room. The resident was not toileted or checked for incontinence. On 08/04/11 from 12:25 P.M. - 12:40 P.M., Resident #E was noted to be visiting with family members. At 1:30 P.M., Resident #E was transferred by CNA's #3 and #6 from the wheelchair into his bed. The resident's brief was wet and there was a slight smear of bowel movement noted. In addition, there were large deep indentations from the brief and			

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	pad noted on the resident's buttocks and posterior upper thigh. The clinical record for Resident #E was reviewed on 08/04/11 at 1:05 P.M. The most recent MDS assessment for Resident #E, completed on 07/29/11, indicated the resident required extensive staff assistance of two for toileting needs, and was totally incontinent of his bladder and frequently incontinent of his bowels. The current health care plans, current as of 08/11 indicated the resident required an "Incontinence management" program and was to be checked every two hours for incontinence. 6. On 08/04/11 at 9:20 A.M., Resident #C was observed seated in a Broda reclining chair in the hallway near her room. She was placed in the doorway of her room at 10:20 A.M. She remained in her wheelchair in the doorway to her room, until 10:55 A.M., when she was pushed by staff to the assisted dining room. The resident was not checked for incontinence or toileted. At 12:25 P.M., on 08/04/11, Resident #C was observed back in her Broda chair in the doorway to her room. She remained in her Broda chair until 1:22 P.M., when CNA's #3 and #6 placed her in bed and changed her brief. CNA #3 indicated Resident #C's brief was saturated. She was not toileted.			

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Resident # C's record was reviewed 8/4/2011 at 1:45 p.m. Resident #C's diagnoses included but were not limited to; heart failure, high blood pressure and osteoporosis.

Resident #C's care plan, dated 3/2011, indicated she was to be toileted with a two person physical assist, but the care plan did not indicate the frequency.

Resident #C's Minimum Data Set, dated 6/7/2011, indicated she was extensive assistance with toileting and needed two person physical assistance.

7. Resident #D was observed on 08/03/11 at 7:00 P.M., seated in her room in her wheelchair beside her bed. Her roommate, alert and oriented Resident #S, was noted to frequently come out into the hallway to the nurse's station and request assistance for her roommate, Resident #D. Resident #D remained in her wheelchair beside her bed until 7:53 P.M., when she was transferred by four staff members into her bed.

Resident #D was observed on 08/03/11 at 7:53 P.M., receiving incontinence care. The resident was noted to have an unfastened incontinence brief on and had been incontinent of bowel when she was

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	transferred from the wheelchair to her bed. The resident was noted to have an open pressure ulcer on her upper right buttock. Resident #D's buttocks were noted to be bright red and she had a 4 centimeter by 3 centimeter open area on her right upper buttocks. A Nursing Admission Assessment, dated 8/2/2011, indicated Resident #D had been readmitted from the hospital with the open area on the buttocks. Interview with CNA #8, on 08/03/11 at 10:00 P.M., indicated Resident #D had been transferred to her bed the previous evening by ambulance staff after having been readmitted from an acute care center to the facility. She indicated she was unable to toilet and/or check the resident prior to 7:53 P.M., when she was observed being transferred to her bed because she needed assistance and was unsure of the method going to be utilized to transfer Resident #D. Interview on 8/3/2011 at 8:30 P.M., with Resident #D and her roommate, Resident #S, indicated she had not been toileted since she had received a shower around 10:30 A.M.			

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	On 08/04/11 at 10:00 A.M., Resident #D was changed and transferred to her wheelchair by CNA's #3 and #6. She remained in her wheelchair in the hallway by the telephone until 11:12 A.M., when she was taken to the shower room by CNA #13 and weighed in her wheelchair. She was then placed back out by the telephone and the nurse's station on the east unit. At approximately 11:20 A.M., Resident #D was pushed in her wheelchair by LPN #9 to the dining room for lunch. She was not toileted or checked for incontinence prior to being pushed to the dining room. On 08/04/11 at 12:25 P.M., Resident #D was again in her wheelchair by the nurse's station. At 1:12 P.M., LPN #9 pushed Resident #D back to her room to braid her hair. She was immediately placed back out in the hallway by the nurse's station after her hair was braided. She was not toileted. At 2:00 P.M., Resident #D remained in her wheelchair in the hallway across from the nurse's station. Resident #D's husband picked her up to go to her grandson's birthday party around 2:10 P.M. The resident was not toileted prior to leaving the facility. The clinical record for Resident #D was reviewed on 08/05/11 at 8:10 a.m. Resident #D's diagnoses included but			

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	were not limited to diabetes, stroke, and seizure disorder. Resident #D's care plan, dated 8/2011, indicated she was to be toileted with a two person physical assist, but the care plan did not indicate the frequency or that a Hoyer lift (mechanical lift) was to be used. Resident #D's Minimum Data Set, dated 7/20/2011, indicated she was extensive assistance with toileting and needed two person's physical assistance. 8. On 08/03/11 at 7:00 P.M., Resident #H was observed in her wheelchair beside her bed. CNA #8 was noted to be in the room changing the bed linens. Resident #H was heard requesting to go to bed. She indicated she was hurting because she had been sitting so long (in her wheelchair). At 7:35 P.M., Resident #H was noted to be her bed. Interview with CNA #8 on 08/03/11 at 10:00 P.M., indicated she had toileted Resident #H before supper about 5:30 P.M., when she got her up from bed. She indicated the resident had not been checked again for incontinence until she was placed in bed. Resident #H's record was reviewed			

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COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DRIVE FORT WAYNE, IN46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	8/4/2011 at 1:00 p.m. Resident #H's diagnoses included but were not limited to diabetes, stroke, and seizure disorder. On 8/5/2011 at 11:10 A.M., perineal care was observed on Resident #H. Her brief was noted to be saturated with urine on removal. Her skin was pink with no open areas noted. Resident #H's care plan, dated 7/2011, indicated she was to be toileted with a two person physical assist, but the care plan did not indicate the frequency or that a Hoyer lift was to be used. Resident #H's Minimum Data Set, dated 7/15/2011, indicated she was extensive assistance with toileting and needed two persons physical assistance. This Federal tag relates to Complaint IN00094006. 3.1-38(a)(3)(A)			

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F0353 SS=E	The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview and record review, the facility failed to provide adequate staffing to meet the toileting needs of 8 of 10 incontinent residents reviewed for toileting on the East unit. This has the potential to affect 20 of 33 residents residing on the East unit. (Resident #C, Resident #D, Resident #E, Resident #F, Resident #G, Resident #H, Resident #I and Resident #K) Findings include: During initial tour on 8/3/2011 at 7 p.m., two licensed nurses and two CNAs were observed to be assigned to work on the East unit. The East unit had a census of 33	F0353	F 353 1. Resident's C, D, E, F, G, H, I, and K have been reviewed and have not experienced any negative outcome. 2. As stated in the 2567, the facility had added staff and realigned duties in an effort to assist the staff in completing their tasks and was monitoring the effectiveness. Additionally, the facility redistributed nursing staff over the units to decrease the staff:resident ratio. Interview with staff indicates the new pattern is working well and allows them more time to spend with residents. 3. Nursing staff were inserviced on the redistribution of staff and encouraged to give	08/30/2011

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	residents according to the resident roster. 1. a. Resident #I was observed on 08/03/11 at 7:00 P.M., lying in her bed asleep. The resident remained in her bed from 7:00 P.M. - 11:04 P.M. and was not checked for incontinence or offered toileting. At 10:10 P.M., CNA's #5 and #8 scheduled to work second shift had left and there was only one CNA left working on the East unit. CNA #11 indicated she worked alone until 12:00 midnight when another CNA came in to work. Resident #I was on every two hour check and change. b. Resident #K was observed on 08/03/11 at 7:00 P.M., seated in a reclining Broda chair by the nurse's station. The resident was noted to be actively trying to get up out of her chair. At 7:27 P.M., LPN's #10 and #12 pushed Resident #K to her room, changed her and put her to bed. From 7:27 - 11:04 P.M., Resident #K remained in her room in her bed. She was not checked for incontinence. Resident #K was on every two hour check and change. Interview with CNA #5, on 08/03/11 at 10:00 P.M. indicated Resident #K had been in bed in the afternoon and had been checked for incontinence prior to getting		feedback/suggestions on recent changes. DON/designee will monitor effectiveness 3x weekly through observations and interview. Results of audits will be forwarded to QA&A for tracking and trending monthly times 3 months then quarterly thereafter	

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	her up for supper. c. Resident #F was observed on 08/03/11 at 7:00 P.M., lying in her bed. She remained in her bed, from 7:00 P.M. - 11:04 P.M., and no staff were noted to perform any incontinence care for Resident #F. Interview with CNA #8, on 08/03/11 at 7:00 P.M., indicated Resident #F had been in bed when she started her shift and she had been checked and changed before she was gotten up for supper. Resident #F was on every two hour check and change. d. Resident #D was observed on 08/03/11 at 7:00 P.M., seated in her room in her wheelchair beside her bed. Her roommate, alert and oriented Resident #S, was noted to frequently come out into the hallway to the nurse's station and request assistance for her roommate, Resident #D. Resident #D remained in her wheelchair beside her bed until 7:53 P.M. when she was transferred by four staff into her bed, CNA's #5 and 8, and LPN's #10 and 12. Resident #D's buttocks was noted to be bright red and she had an open area on her right upper buttocks, and she had been incontinent of her bowels. Interview with CNA #8, on 08/03/11 at 10:00 P.M., indicated Resident #D had			

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	been transferred to her bed the previous evening (8/2) by ambulance staff after having been readmitted from an acute care center to the facility. She indicated she was unable to toilet and/or check the resident prior to 7:53 P.M., when she was observed being transferred to her bed because she needed assistance and was unsure of the method going to be utilized to transfer Resident #D. Resident #D was on every two hour check and change. Interview with Resident #D and her roommate, Resident #S, following the observation, indicated she had not been toileted since she had received a shower around 10:30 A.M. e. On 08/03/11 at 7:00 P.M., Resident #H was observed in her wheelchair beside her bed. CNA #8 was noted to be in the room changing the bed linens. Resident #H was heard requesting to go to bed. She indicated she was hurting because she had been sitting so long (in her wheelchair). At 7:35 P.M., Resident #H was noted to be her bed. Resident #H was on an every two hour check and change schedule. Interview with CNA #8 on 08/03/11 at 10:00 P.M., indicated she had toileted Resident #H before supper when she got her up from bed. She indicated the			

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	resident had not been checked again for incontinence until she was placed in bed. 2. a. On 08/04/11 at 9:20 A.M., Resident #I was noted to be in the main lounge at a Catholic church service. Resident #I remained in the main lounge until 11:21 A.M., when the Beautician, whose shop was located adjacent to the main lounge, indicated the resident was taken from the main lounge to the dining room by activity staff. At 1:12 P.M., CNA #6 was noted to assist Resident #I to bed. Interview with CNA #6 indicated the resident was a one person transfer and she was to be checked and changed. She indicated she changed the resident when she put her to bed, but she did not offer to toilet the resident. b. On 08/04/11 at 9:20 A.M., Resident #K was observed seated in her reclining Broda chair by the nurse's station asleep. The resident remained in her reclining chair from 9:20 A.M. - 10:55 A.M., when she was taken by CNA #3 to the assisted dining room for lunch. At 12:20 P.M., CNA #3 put resident #K to bed and changed her incontinence brief. c. On 08/04/11 at 9:20 A.M., Resident #G was observed seated in her wheelchair			

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	across from the nurse's station. The resident indicated she needed help because she was afraid of people trying to "get her." LPN #9 was alerted and reassured and talked with Resident G. Resident #G remained in her wheelchair across from the nurse's station from 9:20 - 11:09 A.M. At 11:09 A.M., LPN #9 pushed Resident #G to the assisted dining room. She was not toileted or offered to be changed prior to going to the dining room. At 12:25 P.M.,on 08/04/11, Resident #G was noted to be in her wheelchair in the main lounge, awake, watching television. At 1:25 P.M., LPN #9 pushed Resident #G from the main lounge to her room and left her in her wheelchair beside her bed. At 2:00 P.M., CNA's #3 and #6 transferred Resident #G to her bed and changed the resident. Resident #G's brief was wet, there were scars from previous open areas, but the resident skin was not open. Resident #G was on an every two hour check and change schedule. d. On 08/04/11 at 9:20 A.M., Resident #F was observed lying in a reclining Broda chair across from the nurses station. She remained in the Broda chair asleep from 9:20 A.M. - 10:45 A.M. At 10:45 A.M., two unidentified staff members were observed to reposition and pull the			

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	resident up in the Broda chair. At 11:04 A.M., CNA #3 pushed Resident #F to the assisted dining room. She was not checked for incontinence or toileted. On 08/04/11 at 12:25 P.M., Resident #F was observed still in her Broda chair by the nurse's station in the hallway. At 1:00 P.M., CNA's #3 and #6 transferred Resident F from her reclining chair to her bed with a mechanical lift. The resident's brief was changed and the resident was noted to have been incontinent of both her bladder and bowels. e. On 08/04/11 at 9:20 A.M., Resident #E was noted to be in his wheelchair in the main lounge at an activity. He remained in the main lounge from 9:20 - 11:20 A.M. At 11:20 A.M., CNA #6 put his feet up on the wheelchair pedals and pushed him directly to the dining room. The resident was not toileted or checked for incontinence. On 08/04/11 from 12:25 P.M. - 12:40 P.M., Resident #E was noted to be visiting with family members. At 1:30 P.M., Resident #E was transferred by CNA #3 and #6 from the wheelchair into his bed. The resident's brief was wet and there was a slight smear of bowel movement noted. In addition, there were large deep indention from the brief and			

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	pad noted on the resident's buttocks and posterior upper thigh. Resident #E was on an every two hour check and change schedule. f. On 08/04/11 at 9:20 A.M., Resident #C was observed seated in a Broda reclining chair in the hallway near her room. She was placed in the doorway of her room at 10:20 A.M. She remained in her wheelchair in the doorway to her room, until 10:55 A.M., when she was taken by staff to the assisted dining room. The resident was not checked for incontinence or toileted. At 12:25 P.M., on 08/04/11, Resident #C was observed back in her Broda chair in the doorway to her room. She remained in her Broda chair until 1:22 P.M., when CNA's #3 and #6 placed her in bed and changed her brief. She was not toileted. Resident #C was on an every two hour check and change schedule. g. On 08/04/11 at 10:00 A.M., Resident #D was changed and transferred to her wheelchair by CNA's #3 and #6. She remained in her wheelchair in the hallway by the telephone until 11:12 A.M., when she was taken to the shower room by CNA #13 and weighed in her wheelchair. She was then placed back by the telephone and the nurse's station on the East unit. At approximately 11:20 A.M., Resident #D was pushed in her			

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	wheelchair by LPN #9 to the dining room for lunch. She was not toileted or checked for incontinence prior to being taken to the dining room. On 08/04/11 at 12:25 P.M., Resident #D was again in her wheelchair by the nurse's station. At 1:12 P.M., LPN #9 pushed Resident #D back to her room to braid her hair. She was immediately placed back out in the hallway by the nurse's station after her hair was braided. She was not toileted. At 2:00 P.M., Resident #D remained in her wheelchair in the hallway across from the nurse's station. Resident #D indicated her husband was picking her up to go to her grandson's birthday party around 2:00 P.M. 3. A review of the staffing pattern as worked from 7/1/2011 to 8/5/2011 provided by the Director of Nursing on 8/4/2011 at 8:40 a.m., indicated two licensed nurses and two CNAs were routinely assigned to the East unit for day and evening shifts consistently to care for 33 residents. Additionally, one nurse and one CNA was assigned for night shift 17 of the 36 days. Two CNAs were assigned on night shift the other 19 days. In an interview on 8/3/2011 at 8:25 p.m. LPN #4 indicated two CNAs were not enough to be able to toilet those who			

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	needed it every two hours. In an interview on 8/3/2011 at 8:28 p.m., CNA #5 indicated it was very hard to get everyone toileted before bed and they sometimes could not get finished with toileting because they did not have enough time. In an interview on 8/4/2011 at 12:35 p.m., CNA #6 indicated sometimes there was not enough staff to get everything done. CNA #6 additionally indicated administration had been made aware of the issue and was unwilling to change. Interview with CNA #11, on 08/03/11 at 11:00 P.M., indicated she was the only CNA working from 10:00 P.M. - 12:00 A.M. on the third shift. Interview with CNA's #3 and #6, on 08/04/11 at 1:00 P.M., indicated there was not always enough time to toilet and/or change incontinent residents on the unit on the day shift. Both CNAs indicated the licensed nurses tried to help with answering call lights and taking care of some care needs, but there still was not always enough time to get all the toileting and/or incontinence checks completed. Interview with CNA #8, on 08/03/11 at 8:00 P.M., indicated she could not always			

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	get all of the toileting and incontinence care done due to the number of residents on the East Unit who required mechanical lifts, which took extra time. CNA's #8 and #5 indicated they had 12 residents who required a mechanical lift and 2 more residents who were being considered for a mechanical lift transfer. A form, presented by the DON on 08/04/11 at 10:00 A.M., indicated there were 33 residents on the East unit, 26 required a 1 person assist for toileting needs, 1 person who required a two person assist for toileting needs, and 10 residents who required a mechanical lift for transfers, and 16 resident who required a 1 person assist for transfers. Observations of care on 08/03/11 from 7:00 P.M. - 11:00 P.M., and on 08/04/11 from 9:20 A.M. - 11:20 A.M. and 12:25 P.M. - 2:00 P.M., indicated the mechanical lift transfer and incontinence checks required a minimum of 10 minutes of staff time and required two staff present. Thus, 10 minutes times 10 mechanical lift residents took 100 minutes of staff time per CNA. When repeated four times in a shift, as indicated in each resident's care plan, an incontinence check and transfer with a mechanical lift would utilize 400 minutes of the total 420 minutes of staff per CNA for one shift,			

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	after subtracting 30 minutes for a staff meal break. Thus, there would only be approximately 20 minutes of CNA staff time per CNA to utilize to toilet the other 26 residents who required assistance to toilet, dress the other 16 residents, assist in the dining room during two meals on the day shift and one meal on the evening shift, pass any extra nourishment snacks, assist residents with transportation to and from activities and meals, and provide showers as scheduled. In an interview with the Director of Nursing on 8/5/2011 at 11:20 A.M., she indicated the facility had been working on staffing having recognized it was hard for the CNAs to get their work completed. A document was provided during the interview indicating a second CNA was added to 6 of the 8 hours on the third shift on May 25, 2011. The get up list had been adjusted for the night and day shift the second week of June, but the exact date was not indicated, Shower redistribution was implemented on July 25, 2011. The shower redistribution changed the times of the showers to before meals. The facility was still monitoring this change to evaluate its effectiveness. She indicated staff could ask for help if they were unable to get their assignments completed and she felt the East Unit was adequately staffed and was "over budget."			

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	Refer to F282 related to failure to follow health care plans related to toileting, incontinence management and mechanical lift transfers. Refer to F312 related to failure to ensure dependent for care residents were toileted and/or, provided timely incontinence care. This Federal tag relates to Complaint IN00094006. 3.1-17(a)			

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F0441 SS=E	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review, and interview, the facility failed to ensure 3 of 4 staff observed providing incontinence care followed the facility policy regarding glove use and cleaning technique. This	F0441	F 441 1. Residents D, E, F, and H have been reviewed and has not experienced any negative outcome. 2. The facility reviewed infection control logs with no trends noted.	08/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	08/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DRIVE FORT WAYNE, IN46804

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	affected 4 of 10 residents observed for incontinence care in a sample of 10. (Residents D, E, F, and H) Findings include: 1. Resident #D was observed on 08/03/11 at 7:53 P.M., receiving incontinence care. The resident was noted to have on an unfastened incontinence brief and had been incontinent of bowel when she was transferred from the wheelchair to her bed. CNA #8 was noted to bring one soapy, wet washcloth and one wet washcloth and one dry towel to the bedside. After donning gloves, CNA #8 was noted to wash the resident's perineal area folding both sides of the soapy and rinse washcloths as she washed. LPN #12 then reentered the room and donned gloves, utilized the soiled washcloths to wipe flecks of bowel movement up and across the resident's buttock area. The resident was noted to have an open pressure ulcer on her upper right buttock. 2. CNA's #3 and 6 were observed transferring and providing incontinence care for Resident #F on 08/04/11 at 1:00 P.M. CNA #3 was noted to don gloves and clean the resident's perineal area and buttock area. The resident had been incontinent of a large amount of soft stool. CNA #3, then without removing		Central supply has increased the number of times gloves are passed weekly and placed a supply in a central location for staff use. 3. Nursing staff will be inserviced on proper glove usage and cleaning techniques for incontinent residents. Nursing staff has been inserviced on where to find extra supplies of gloves and how to obtain. SDC/designee will monitor compliance through random observations 2x weekly. 4. Results of audits will be forwarded to QA&A for tracking and trending monthly times 3 months then quarterly thereafter.	

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	his contaminated gloves, adjusted the resident's oxygen tubing and clipped the call light to the bed sheet before removing his gloves. 3. CNA's #3 and 6 were observed performing incontinence care for Resident #E on 08/04/11 at 1:30 P.M. CNA #6 was noted to clean the resident's perineal and buttock area with gloved hands. The resident had been incontinent of urine and a small amount of bowel movement. After cleaning the resident, CNA #6 did not remove her gloves before pulling up the blankets for Resident #E. 4. During an observation on 8/5/2011 at 11:00 a.m. CNA #3 performed hand hygiene and gloved. CNA #3 then washed Resident #H's perineal area, rinsed, and then dried the area appropriately. CNA #3 then proceeded to apply a clean brief, reposition the resident and pull up the blankets without taking off gloves or performing hand hygiene. A current policy dated 2006 titled Perineal Care indicated to change gloves after drying the resident and before repositioning or covering the resident up. In an interview on 8/3/2011 at 8 p.m., LPN #1 indicated gloves were allocated to the residents by one person and the staff did not have a key to get into the area			

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	where the supply of gloves were kept. In an interview on 8/4/2011 at 9:30 A.M., CNA #2 indicated having adequate boxes of gloves in the room to care for residents was an issue. On 8/5/2011 at 11:00 a.m., during observation of care, CNA #3 indicated glove availability was an issue at times, but had plenty of gloves today. This Federal tag relates to Complaint IN00094006. 3.1-18(l)			